

**Minor Child History
Parent/Guardian Authorization
For Emergency Medical Treatment
And Immunization's.
(Please fill out form completely and sign)**

I, _____, the natural parent (or legal guardian) hereby gives
permission that my child, _____

STUDENTS NAME (LAST)

(FIRST)

Soc. Security # _____ Date of Birth _____

Street Address

City

Zip

Area Code & Home Phone Number

- May be given emergency treatment to include first aid and CPR by qualified staff at the internship site. I authorize and consent to medical, surgical and hospital care. Treatment and procedures may be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.
- I further give permission for my son/daughter to receive a baseline tuberculin skin test (tbt) (PPD).
- I further give permission for my son/daughter to be followed by the hospital's policy/protocol for any incident that is related to a Blood Borne Pathogen Exposure.

The following information will be used for obtaining emergency medical treatment in case of injury or illness during training. Please make sure to fill out completely.

Parent/Guardian/Adult to Contact in Case of Emergency

Relationship to Student

Street Address

City

Zip

Area Code & Home Phone Number

Area Code & Cell Phone Number

Area Code & Work Phone Number

*Alternate Adult in Case Above Person Cannot be Reached

Area Code & Phone Number

Students Personal Family Doctor: _____ Phone: _____

Doctor's Address _____

Hospital Preference _____

- **Has your son/daughter ever suffered from any of the following: (Please check all that apply)**

Asthma _____ Epilepsy _____ TB _____ Diabetes _____ Sight Impaired _____ Back Problems _____

Hernia _____ Heart Disease _____ Hearing-Impaired _____ Stomach Disorder _____ Diabetes _____

High Blood Pressure _____ Low Blood Pressure _____ Hypoglycemia _____ None _____ Other _____

PLEASE TURN OVER AND FILL OUT THE BACK SIDE OF THIS PAPER COMPLETELY.

(specify)

- **Does your son/daughter have allergies to any of the following: YES [] NO []**
(Please check all that apply)

Grass _____ Bee Stings _____ Sun _____ Dust _____ Cleaning Products _____ Latex _____

List any other allergies _____

- **Is your son/daughter currently taking any medication? Yes [] No []**

If YES, please list _____

- **Is your son/daughter allergic to any medications? Yes [] No []**

If YES, please list _____

- **Has your son/daughter ever received a BCG inoculation? (This is a common vaccination that they might have received as a child if born in a foreign country). Yes [] No []**

- **Has your son/daughter ever had a positive (red and raised injection site) TB test? Yes [] No []**
(This is a test for TB)

- **Has your son/daughter ever had a allergic reaction to the TB test Yes [] No []**

- **Is the student listed on this form currently pregnant? Yes [] No []**

If YES, please give due date _____

- **Does your son/daughter have any physical condition that would prevent him/her from doing certain types of work? Yes [] No []**

If YES, please explain _____

- **Does your son/daughter have any mental condition that would prevent him/her from doing certain types of work? Yes [] No []**

If YES, please explain _____

- **Approximate date of your son's/daughter's last Tetanus shot: _____**

- **Please indicate whether your son/daughter may receive the annual FLU SHOT: Yes [] No []**

PARENT/GUARDIAN SIGNATURE***

DATE

*** This signature authorizes emergency medical treatment and immunizations